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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **MARIE BEGAY SULLIVAN** **1975 East University Drive, #275** **Tempe, AZ 85281** **Registered Nurse License No. 264656** Respondent.	Case No. 2010-45 **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN ("Complainant") brings this Accusation solely in her official capacity as the Interim Executive Officer of the Board of Registered Nursing ("Board"), Department of Consumer Affairs.

2. On or about March 31, 1976, the Board issued Registered Nurse License Number 264656 to Marie Begay Sullivan ("Respondent"). Respondent's registered nurse license expired on December 31, 2001.

STATUTORY PROVISIONS

3. Business and Professions Code ("Code") section 2750 provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive

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license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

4. Code section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under Code section 2811, subdivision (b), the Board may renew an expired license at any time within eight years after the expiration.

5. Code section 2761 states, in pertinent part:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> (a) Unprofessional conduct, which includes, but is not limited to, the following:
>
> . . . .
>
> (4) Denial of licensure, revocation, suspension, restriction, or any other disciplinary action against a health care professional license or certificate by another state or territory of the United States, by any other government agency, or by another California health care professional licensing board. A certified copy of the decision or judgment shall be conclusive evidence of that action . . .

COST RECOVERY

6. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

CAUSE FOR DISCIPLINE

(Disciplinary Action by the Arizona State Board of Nursing)

7. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a)(4), on the grounds of unprofessional conduct, in that Respondent was disciplined by the Arizona State Board of Nursing (hereinafter "Arizona Board"), as follows: On or about November 10, 2008, pursuant to Consent for Entry of Voluntary Surrender Order No. 08A-0702115-NUR, in the disciplinary proceeding titled *In the Matter of Professional Nurse License No. RN057733 Issued to: Marie Begay-Sullivan*, the Arizona Board accepted the voluntary surrender of Respondent's license to practice professional nursing in that state.

Pursuant to the terms of the order, Respondent admitted that the conduct and circumstances described in the Arizona Board's Findings of Fact constituted violations of A.R.S. § 32-1663(D) as defined in § 32-1601 (d), (g), (h), and (j), and A.A.C. R4-19-403(B)(1), (7), (8)(a), (9), (12), (25)(a), and (31) (adopted effective November 2005); and constituted sufficient cause pursuant to A.R.S. §§ 32-1663 and 32-1664 to take disciplinary action against her Arizona professional nurse license. A true and correct copy of Consent for Entry of Voluntary Surrender Order No. 08A-0702115-NUR is attached hereto as Exhibit A and incorporated herein by reference. The Findings of Fact alleged, in part, as follows:

a. In and between June 1996, and October 2007, Respondent was employed by Health Temp and was assigned at Chandler Regional Hospital in Chandler, Arizona. A complaint was received from Julie Buckwalter, RN, Director of Nursing Support, informing the Arizona Board that on January 25, 2007, Respondent was assigned to patient Z.I. The dayshift nurse reported that Respondent informed her that the insulin drip for Z.I. was discontinued since she did not have time to do hourly accuchecks. According to the dayshift nurse, Respondent turned off the insulin drip after getting an accucheck of 181 after 10:00 p.m. Respondent did not follow protocol nor did she have a physician's order to discontinue the insulin drip. Buckwalter also reported that on January 25, 2007, Respondent provided care for patient D.W. The patient was reported to have a right groin sheath in place after a Percutaneous Transluminal Coronary Angioplasty procedure. Buckwalter reported that Respondent pulled the sheath sometime between 3:30 a.m. and 7:30 a.m. per her documentation, with no IV access, and removed the sheath without assistance or notification of another registered nurse as required by policy.

b. On and between May 21, 2007, and July 8, 2007, Respondent was employed at Mayo Clinic Hospital in Scottsdale, Arizona. On or about July 24, 2007, a complaint was received from Debra Pendergast, RN, of the Mayo Clinic, informing the Arizona Board that Respondent was terminated from her employment on July 8, 2007, due to her inability to demonstrate competencies to provide professional nursing care and failing to maintain minimal standards of acceptable practice based on Corrective Action Forms Respondent had received on or about May 31, 2007, June 15, 2007, July 5, 2007, and July 8, 2007.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 264656, issued to Marie Begay Sullivan;

2. Ordering Marie Begay Sullivan to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: 8/3/09

Louise R. Bailey

LOUISE R. BAILEY, M.Ed., RN
Interim Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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accusation.rtf

EXHIBIT A

CONSENT FOR ENTRY OF VOLUNTARY SURRENDER
ORDER NO. 08A-0702115-NUR

ARIZONA STATE BOARD OF NURSING
4747 North 7th Street, Suite 200
Phoenix, Arizona 85014-3653
602-889-5150

IN THE MATTER OF PROFESSIONAL NURSE LICENSE NO. RN057733 ISSUED TO: MARIE BEGAY-SULLIVAN, Respondent.	**CONSENT FOR ENTRY OF VOLUNTARY SURRENDER** **ORDER NO. 08A-0702115-NUR**

A complaint charging Marie Begay-Sullivan ("Respondent") with violations of the Nurse Practice Act has been received by the Arizona State Board of Nursing ("Board"). In the interest of a prompt and speedy settlement of the above-captioned matter, consistent with the public interest, statutory requirements, and the responsibilities of the Board, and pursuant to A.R.S. §32-1663(D)(5), Respondent voluntarily surrenders her license for a minimum of three years.

Based on the evidence before it, the Board makes the following Findings of Fact and Conclusions of Law:

FINDINGS OF FACT

1. The Arizona State Board of Nursing ("Board") has the authority to regulate and control the practice of nursing in the State of Arizona, pursuant to A.R.S. §§ 32-1606, 32-1663, and 32-1664. The Board also has the authority to impose disciplinary sanctions against the holders of nursing licenses for violations of the Nurse Practice Act, A.R.S. §§ 32-1601 to -1667.

2. Respondent holds Board issued professional nurse license number RN057733 in the State of Arizona.

3. From in or about June 1996 until October 2007, Respondent was employed by Health Temp with an assignment at Chandler Regional Hospital in Chandler, Arizona.

4. A complaint was received from Julie Buckwalter, RN, Director of Nursing Support,

informing the Board that on January 25, 2007, Respondent was assigned to patient, Z.I. The dayshift nurse, Heidi Brewer, RN reported that Respondent informed her that the insulin drip for Z.I. was discontinued since she did not have time to do hourly accuchecks. According to Brewer, Respondent turned off the insulin drip after getting an accucheck of 181 after 10:00 p.m. Respondent did not follow protocol nor did she have a physician's order to discontinue the insulin drip.

5. Buckwalter also reported on January 25, 2007, Respondent provided care for patient D.W. This patient was reported to have a right groin sheath in place after a Percutaneous Transluminal Coronary Angioplasty (PTCA) procedure. Buckwalter reported that Respondent pulled the sheath sometime between 3:30 a.m. and 7:30 a.m. per her documentation with no IV access, and also she removed the sheath without assistance or notification of another registered nurse as required by policy.

6. From on or about May 21, 2007 until July 8, 2007, Respondent was employed at Mayo Clinic Hospital in Scottsdale, Arizona.

7. On or about July 24, 2007, a complaint was received from Debra Pendergast, RN, Mayo Clinic, informing the Board that Respondent was terminated from employment on July 8, 2007 due to inability to demonstrate competencies to provide professional nursing care and failing to maintain minimal standards of acceptable practice.

8. On or about May 31, 2007, Respondent received and signed a Corrective Action Form for the following infractions: Giving an incorrect Social Security number upon hire; arriving 15 minutes late to the unit on May 25, 2007; performing and documenting physical assessment on May 25, 2007 without a stethoscope, and asking her preceptor to provide lung and heart sounds for documentation; not writing down a report on the first day of orientation; failing to properly administer IV piggyback medication and failing to program medication pump properly on May 25, 2007. Respondent also was

noted to have significant difficulty with remembering computer access passwords, following directions and with navigating electronic medical records in general orientation and unit orientation.

9. On or about June 15, 2007, Respondent received and signed a Corrective Action Form for failing to meet performance standards as follows:

- On June 6, 2007, Respondent's preceptor noted Respondent had multiple problems with the computer system even after repeated explanations, resulting in Respondent's inability to document information in a timely manner and identify which medications were due at any given time.
- On June 6, 2007, Respondent's preceptor noted that Respondent had difficulty retaining information. The preceptor informed Respondent that she hung a unit of blood and five minutes later, Respondent stated, "Aren't we supposed to transfuse our patient?"
- On June 7, 2007, Respondent was noted to continue to have difficulty with the computer and her preceptor was telling her every single click to complete her charting. Respondent's preceptor stated that Respondent did not have a good understanding of the cardiac monitors and ventilator alarms.
- Respondent also failed to successfully complete mandatory education/job specific competencies. Respondent did not successfully pass the medication calculation test on June 6, 2007.

10. On or about July 5, 2007, Respondent received and signed a final Corrective Action Form for the following:

- Respondent failed to pass the repeat medication calculation test on July 3, 2007. Her score was 50%.

- The following concerns were noted by Respondent's preceptor on July 3, 2007: Charting was excessively slow as evidenced by taking 20 minutes to document one column on the pain flow sheet and she noted physician orders that were not entered into the IDX system.
- Respondent was unable to figure out if an order was entered in the computer by the unit secretary. She also took five minutes to figure out how to cycle a blood pressure cuff on the GE monitor, five minutes to hook up a CVP, and she did not identify that there was an order for subcutaneous heparin on the chart for more than three hours, and then, only after some prompting from her preceptor. She also had difficulty determining what medications were to be given using the Medication Administration Record (MAR) on the computer.
- Respondent's patient returned from a procedure and she took 15 minutes to hook up the Central Venous Pressure Line (CVP), Tube Feeding and Intravenous (IV) fluids. She also needed continuous prompting to determine how to chart accucheck results and interventions on the flow sheet. Respondent was not able to independently determine how much insulin to administer and did not know what a flowsheet was for vital signs and intake and output. Respondent did not recognize significant changes on the cardiac monitor even when prompted.
- On July 5, 2007, Respondent was 45 minutes late returning from lunch for the computer education class she was required to attend as a part of the action plan from June 15, 2007.

11. On or about July 8, 2007, Respondent received a Corrective Action Form and was involuntarily terminated for the following observations that occurred on July 7 and July 8, 2007:

- Respondent arrived late on the unit for the dayshift and missed half of the report. She had difficulty prioritizing and did not give 9:00 a.m. medications until 11:00 a.m. Respondent did not know what her computer passwords were and the preceptor had to call to obtain the passwords to sign on.
- Respondent checked temperatures on her assigned patients at 8:00 a.m. and did not check them again for the remainder of the shift. She placed the accucheck on the flow sheet but did not chart the insulin given in the MAR or the flow sheet. Respondent's preceptor reviewed with Respondent all of the charting that she was required to complete, but by 6:30 p.m. Respondent had not charted a single flow sheet for her assigned patients.
- At 8:00 a.m., Respondent entered into the IDX assessment module three different entries for one patient. The first two entries for the neurological and cardiovascular assessments were conflicting. Respondent did not update any care plans and did not understand what the drop downs were used for in the flowsheets for the patients assigned. She did not respond to call lights when they went off.
- Respondent documented a patient's incision, but the information was unclear regarding the location and description. Also, Respondent did not complete a shift summary until prompted by her preceptor.

- Respondent did not check her charts throughout the day and she was unaware there were new orders written. She was unable to identify where a physician contact was to be charted and Respondent did not give any medications on time the entire day.

12. On July 8, 2007, Respondent was assigned only one patient for the day due to her extreme difficulty organizing her shift the day prior, but she continued to display difficulty with performance standards.

- Respondent did not resend lab work as ordered because the patient told her that it was already sent.
- A physician spoke to Respondent then contacted the team leader with the following concerns: Respondent obtained an axillary temperature on an alert and oriented patient and was unable to describe a wound and unable to inform him of lab results.
- Respondent's patient had accuchecks scheduled before meals and at bedtime. She informed her preceptor that she completed them. Respondent's preceptor questioned her as to why they were not charted. Respondent acknowledged that she did not complete the accuchecks in the morning or at noon.

13. Respondent signed the Corrective Action Form terminating her employment, but commented in writing that she disagreed to any and all accusations brought against her.

14. From on or about March 26, 2007 until April 5, 2007, Respondent was employed with Matria Healthcare. Respondent's employment was terminated for attendance issues.

15. On or about April 4, 2007, June 4, 2007 and October 1, 2007, investigative questionnaires were mailed to Respondent and were returned to the Board as "Refused-Commercial Mail Receiving Agency. No authorization to receive mail for this address."

16. On or about November 16, 2007, Respondent left a voice message for Board staff inquiring about the status of her case, stating she would contact the Board the following day. Respondent did not contact Board staff nor did she provide a telephone number to contact her.

17. On or about November 18, 2007, Respondent contacted Board staff. She requested additional time to complete the investigative questionnaire and she was told that her case would be reviewed by the Board in January 2008.

18. On or about November 19, 2007, an investigative questionnaire was mailed to Respondent. Respondent did not respond.

19. On or about December 4, 2007, Respondent contacted Board staff. She stated she should not have been terminated from Mayo Clinic because she had been doing medication calculations for a long time. She reported her father was dying at that time and she was very upset. Respondent disclosed she was not very good with computers and had difficulty remembering codes.

20. On or about October 29, 2008, Respondent requested to voluntary surrender her license.

CONCLUSIONS OF LAW

Pursuant to A.R.S. §§ 32-1606, 32-1663, and 32-1664, the Board has subject matter and personal jurisdiction in this matter.

1. The conduct and circumstances described in the Findings of Fact constitute violations of A.R.S. §32-1663(D) as defined in § 32-1601 (d), (g), (h) and (j), and A.A.C. R4-19-403(B)(1), (7), (8)(a), (9), (12), (25)(a) and (31)(adopted effective November 2005).

2. The conduct and circumstances described in the Findings of Fact constitute sufficient cause pursuant to A.R.S. §§ 32-1663 and 32-1664 to take disciplinary action against Respondent's license to practice as a professional nurse in the State of Arizona.

Respondent admits the Board's Findings of Fact and Conclusions of Law.

Respondent understands that she has an opportunity to request a hearing and declines to do so. Respondent agrees to issuance of the attached Order and waives all rights to a hearing, rehearing, appeal, or judicial review relating to this Order.

Respondent understands that all investigative materials prepared or received by the Board concerning these violations and all notices and pleadings relating thereto may be retained in the Board's file concerning this matter.

Respondent understands that the admissions in the Findings of Fact are conclusive evidence of a violation of the Nurse Practice Act and may be used for purposes of determining sanctions in any future disciplinary matter.

Respondent understands the right to consult legal counsel prior to entering into the Consent Agreement and such consultation has either been obtained or is waived.

Respondent understands that this Voluntary Surrender is effective upon its acceptance by the Executive Director or the Board and by Respondent as evidenced by the respective signatures thereto. Respondent's signature obtained via facsimile shall have the same effect as an original signature. Once signed by the Respondent, the agreement cannot be withdrawn without the Executive Director or the Board's approval or by stipulation between the Respondent and the Executive Director or the Board. The effective date of this Order is the date the Voluntary Surrender is signed by the Executive Director or the Board and by Respondent. If the Voluntary Surrender is signed on a different date, the later date is the effective date.

Respondent understands that Voluntary Surrender constitutes disciplinary action. Respondent also understands that she may not reapply for reinstatement during the period of Voluntary Surrender.

Respondent agrees that she may apply for reinstatement after the period of Voluntary Surrender under the following conditions, and must comply with current law at the time of her application for

reinstatement:

The application for reinstatement must be in writing and shall contain therein or have attached thereto substantial evidence that the basis for the Voluntary Surrender has been removed and that the reinstatement of the license does not constitute a threat to the public's health, safety and welfare. The Board may require physical, psychological, or psychiatric evaluations, reports and affidavits regarding Respondent as it deems necessary. These conditions shall be met before the application for reinstatement is considered.

Marie Begay-Sullivan, RN

Marie Begay-Sullivan
Respondent

Date: November 10, 2008

ARIZONA STATE BOARD OF NURSING

SEAL

Joey Ridenour

Joey Ridenour, R.N., M.N., F.A.A.N.
Executive Director

Dated: 11/10/08

ORDER

Pursuant to A.R.S. § 32-1663 (D)(5) the Board hereby accepts the Voluntary Surrender of professional nurse license number RN057733, issued to Marie Begay-Sullivan. This Order of Voluntary Surrender hereby entered shall be filed with the Board and shall be made public upon the effective date of this Consent Agreement. Respondent shall not practice in Arizona under the privilege of a multistate license.

IT IS FURTHER ORDERED that Respondent may apply for reinstatement of said license after a period of three years.

ARIZONA STATE BOARD OF NURSING

SEAL

Joey Ridenour, R.N., M.N., F.A.A.N.
Executive Director

Dated: 11/10/08

COPY mailed this 10th day of November, 2008, by First Class Mail to:

Marie Begay-Sullivan
5225 E Thomas #122
Phoenix AZ 85018

By: Vicky Driver